

2011 Retiree Benefit Election Form



Complete ALL sections – If not enrolling, select “I Decline”. *IMPORTANT:* All participants must provide a social security number to enroll. Retirees and/or family members enrolled in a City plan AND eligible for Medicare must complete Section III below and provide a copy of your Medicare card to the City.

I. Personal Information - please print

Coverage Effective Date _____

Name _____

☐ Retiree (RET) *☐ Surviving Spouse (Surv Sp)

*Name and Social Security Number of City Retiree _____

Daytime Phone _____ Cell Phone _____

Mailing Address: _____

Address Changes? ☐ Yes ☐ No E-mail address _____

II. Retiree & dependent Information

Relationship and Plan	Name	Birthdate	*Social Security No.	Action
<input type="radio"/> RETIREE <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Drop <input type="radio"/> No change
<input type="radio"/> SPOUSE <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Drop <input type="radio"/> No change
<input type="radio"/> DAUGHTER <input type="radio"/> SON <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Drop <input type="radio"/> No change
<input type="radio"/> DAUGHTER <input type="radio"/> SON <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Drop <input type="radio"/> No change

*Social Security Number is REQUIRED

III. Medicare Information

Last Name, First Name	Relationship	Eligible Date	Effective Date	Medicare Number	(Y= Yes N = No)		
					Part A	Part B	Part D

IV. METLIFE Dental Place an “X” in the appropriate box below:

Plan	Ret or Surv Sp Only	Ret or Surv Sp & one dependent	Ret or Surv Sp & two or more depts.
DHMO	<input type="radio"/> \$9.60	<input type="radio"/> \$18.23	<input type="radio"/> \$27.34
PPO Low	<input type="radio"/> \$12.53	<input type="radio"/> \$24.83	<input type="radio"/> \$43.71
PPO High	<input type="radio"/> \$30.23	<input type="radio"/> \$59.86	<input type="radio"/> \$105.38

☐ I decline DENTAL coverage for: ☐ myself / ☐ my spouse / ☐ my dependent children DUE TO: ☐ Existence of other coverage / ☐ Don't want/need

V. EYEMED Vision Place an “X” in the appropriate box below:

Plan	Ret or Surv Sp Only	Ret or Surv Sp & one dependent	Ret or Surv Sp & two or more depts.
Vision Plan	<input type="radio"/> \$4.72	<input type="radio"/> \$9.90	<input type="radio"/> \$15.09

☐ I decline VISION coverage for: ☐ myself / ☐ my spouse / ☐ my dependent children DUE TO: ☐ Existence of other coverage / ☐ Don't want/need

For office use only:

Rev. 9/10

Lawson # _____

Medical _____

R x 65 _____

Coverage Eff Date _____

Dental _____

Term File _____

Documentation _____

Vision _____

Lawson _____

Coupon Book _____

Med 65 _____

Finance _____

Retiree Medical / Pharmacy Plan Options

REMINDER: The City contribution toward medical coverage is based on the year of your retirement.

Year of Retirement _____

☐ Retirement before 2008: **Select your Years of Service:** ☐ 10-14 ☐ 15-19 ☐ 20-24 ☐ 25-29 ☐ 30 and over

☐ Retirement after 2007: **Enter your Years of Service:** 10, 11, 12, 13, ..., 30 & Over _____

VI. Under Age 65 Plan Enrollment - UnitedHealthcare Medical & Pharmacy (Rx)

Plan	Select Coverage Level	Enter Your Monthly Cost
<input type="radio"/> Value Medical & Rx	<input type="checkbox"/> RET only <input type="checkbox"/> Spouse only (RET 65+)	
<input type="radio"/> Core Medical & Rx	<input type="checkbox"/> RET + Spouse <input type="checkbox"/> Surv Sp only	\$ _____
<input type="radio"/> Plus Medical & Rx	<input type="checkbox"/> RET + Child or Children <input type="checkbox"/> Surv Sp + Child or Children	Refer to 2011 Monthly Rate Chart
	<input type="checkbox"/> RET + Family	at www.arlingtontx.gov

☐ I decline MEDICAL and Rx coverage for: ☐ myself / ☐ my spouse / ☐ my dependent children

DUE TO: ☐ Existence of other coverage / ☐ Don't want/need

VII. Age 65+ Plan Enrollment - Medicare Advantage or AARP Supplement Plan

Note: Both Secure Horizons and AARP require you complete their form and mail it to them to enroll. To change or drop coverage you are required to complete a City form AND personally notify AARP / Secure Horizons regarding your change in enrollment decisions. The City is not authorized to enroll, change, or drop coverage in these plans for you. You will be responsible for 100% of all billings for plans you enroll in if you do not notify both the City and Secure Horizons and/or AARP of your enrollment change.

Plan	Select Coverage Level	Enter Your Monthly Cost
<input type="radio"/> Secure Horizons with Rx	<input type="checkbox"/> RET only <input type="checkbox"/> Spouse only (RET <65)	\$ _____
<input type="radio"/> AARP K Supplement	<input type="checkbox"/> RET + Spouse <input type="checkbox"/> Surv Sp only	Refer to 2011 Monthly Rate Chart
<input type="radio"/> AARP F Supplement		at www.arlingtontx.gov

☐ I decline MEDICAL coverage for: ☐ myself / ☐ my spouse

DUE TO: ☐ Existence of other coverage / ☐ Don't want/need

VIII. Age 65+ Pharmacy Plan Enrollment - UnitedHealthcare Medicare Part D Rx Plan

Plan	Coverage Level	Years of Service	Your Monthly Cost
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Note: If at any time you are eligible for Medicare Part D and you decline this coverage, you are required to complete a UnitedHealth Rx Part D – Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage form and return to Workforce Services, P.O. Box 90231 MS 63-0790, Arlington, TX 76004-3231 along with this Retiree Insurance Election Form.

☐ UHC Medicare Part D _____

☐ I decline PART D PHARMACY coverage for: ☐ myself / ☐ my spouse **DUE TO:** ☐ Existence of other coverage / ☐ Don't want/need

IX. Monthly Cost Payable to City of Arlington Insurance

Enter the cost of each plan you have enrolled here:

\$ _____ + \$ _____ + \$ _____ + \$ _____ + \$ _____ = \$ _____
Dental Vision Under 65 Medical Secure Horizons or UHC Part D Rx Total Payment Due
AARP Plan (65+ Plans) (65+ Plan) to City Monthly

X. Mailing Address

Enrollment/Change Form:
City of Arlington
Benefits - MS 63-0790
PO Box 90231
Arlington, TX 76004-3231

Monthly Payments:
City of Arlington
Finance Dept. - MS 63-0820
PO Box 90231
Arlington, TX 76004-3231

XI. Signatures

RET or Surv Sp

Date

Workforce Services

Date

NOTE: Failure to complete decline statement may disqualify you for 31 day Special Enrollment Rights (please check all applicable items).